for any outpatient hospital claim is the hospital-specific inpatient per case rate for participating (enrolled) hospitals. When the outpatient cost-based settlements are made, claims for outpatient services which were paid at the per case rate will be excluded from the settlement calculations.

f) Effective for dates of service April 1, 1991, and after, the Department reimburses enrolled hospitals which offer (either directly or through contract) birthing and parenting classes to Medicaid eligible pregnant women. Services may be billed once per year per recipient.

Reimbursement is the lower of billed charges or $70. When the outpatient cost-based settlements are made, claims for outpatient services for birthing and parenting classes will be excluded from the settlement calculations.

g) Effective for dates of service July 1, 1993, and after, a $3 recipient co-payment is required on all non-emergency outpatient hospital visits. Pregnant women, recipients under twenty-one (21) years of age, nursing facility recipients, community care participants, hospice care participants and persons who have both Medicare and Medicaid coverage are not subject to the co-payment. When the outpatient cost-based settlements are made for hospital services, the co-payment plus Medicaid payment will be compared to the allowable cost to determine the amount of final settlement.

Beginning with dates of service of January 1, 1995, co-payments will apply to the groups of recipients outlined below who were previously exempt from participation in co-payments.

1. Dialysis recipients.
2. Medicare/Medicaid dually eligible recipients.
3. Recipients in waivered services programs.

These groups are required to co-pay beginning with dates of service January 1, 1995, and after, for those services designated as co-pay services.

Maintenance dialysis services for end-stage renal disease are not designated as co-payment services and no co-payment is required for these services.

h) Effective for dates of service of July 1, 1993 and after, the professional services of certified registered nurse anesthetists (CRNAs), pediatric nurse practitioners, obstetrical nurse practitioners, family nurse practitioners, and physician's assistant anesthesiologist's assistant (PAAAs) will not be reimbursed through the Medicaid cost report. Effective July 1, 1993, CRNAs, specified nurse practitioners and PAAAs must enroll in the Medicaid program to receive payment for their services directly.

1001.4 Services Provided By Non-Georgia Hospitals

a) Participating (Enrolled) Non-Georgia Hospital

Enrolled non-Georgia hospitals will be paid based on a hybrid-DRG reimbursement system as described in b) and c) below (in greater detail in Appendix C).

Within the DRG portion of the hybrid reimbursement system:

1. The DRG base rate will be the peer group base rate prior to any hospital-specific stop loss adjustment.

2. The per case capital add-on will be based on the peer group average per case capital add-on amount.

Within the CCR portion of the hybrid reimbursement system:

1. The CCR ratio will be based on the peer group average CCR ratio.

2. The per case capital add-on will be based on the peer group average per case capital add-on amount.

Payments to non-Georgia hospitals will not be greater than the rate of payment that would be available from the Medicaid program in their home states. Outpatient services provided by enrolled non-Georgia hospitals are reimbursed at a rate of 65% of covered charges.

b) Nonparticipating (Nonenrolled) Non-Georgia Hospitals

Effective with dates of admission or service of July 1, 1989, and after, inpatient services provided by non-Georgia hospitals not enrolled in the Georgia Medicaid program are reimbursed according to rates established by the Medicaid program in the state in which the hospital is located for those procedures covered by that state. If the state in which the hospital is located reimburses DRG rates or per diem rates exceeding $999.99, reimbursement by Georgia Medicaid will be at a rate not to exceed 65% of covered charges. For procedures or services not covered by the state Medicaid program in the state in which the hospital is located, reimbursement will be at a rate of 65% of covered charges if the procedures or services are covered by Georgia Medicaid.

For certain specialized procedures for which services may not be available at the reimbursement rate as stated above, the Department may approve a percentage of charges rate in excess of 65%.

Outpatient services provided by non-Georgia hospitals not enrolled in the Georgia Medicaid program will be reimbursed at a rate of 65% of covered charges.

1001.5 Medicare Crossover Claims

Effective with dates of payment of October 1, 1990, and after, the maximum allowable payment to enrolled Georgia

and non-Georgia hospitals for Medicare inpatient and outpatient deductible and coinsurance (crossover claims) will be the applicable per case rate under the hybrid-DRG system. The maximum allowable payment to non-Georgia hospitals not enrolled in the Georgia Medicaid program for Medicare inpatient and outpatient crossover claims will be the weighted average inpatient per case rate of enrolled non-Georgia hospitals.

Effective with dates of admission on and after October 9, 1997, the Department will limit payment on outpatient Medicare crossover claims as follows: (a) multiply the allowable deductible and coinsurance amount by the hospital-specific percent of charges rate in effect on the date of payment; (b) compare the product from (a) to the applicable per case rate under the hybrid-DRG system; and (c) reimburse the lower of the two amounts in (b).

Effective with dates of payment on and after October 1, 1995, all outpatient Medicare crossover claims will be reimbursed at 100% of billed charges for Qualified Medicare Beneficiaries (QMBs) only.

1001.6 Third Party Claims

Hospital providers must attempt to pursue third party resources prior to filing a Medicaid claim. If a third party does not pay at or in excess of the applicable Medicaid reimbursement level, a hospital may submit a Medicaid claim and will be paid the applicable reimbursement less any reimbursement received from third party resources. If a third party pays at or in excess of the amount that Medicaid would pay, the hospital should not submit a claim to the Department for payment (see Part 1 Section 303, Third Party Payments). If a claim is submitted, it will be excluded from paid claims data used to establish per case rates and calculate outpatient settlements.

1001.7 Nonallowable Costs

Effective for the determination of reasonable costs used in the establishment of rates effective on and after July 1, 1991, the costs listed below are nonallowable:

1) Costs related to lobbying and government relations, including costs for employees with duties related to lobbying and government relations, honorariums and reimbursement of travel or other expenses of elected officials;

2) Memberships in civic organizations;

3) Out-of-state travel paid by the provider for persons other than board members or those employed or contracted by the provider. Out-of-state travel for provider personnel must be related to patient care;

4) Vehicle depreciation or vehicle lease expense in excess of the lesser of IRS limits per vehicle or the amount allowed under Medicare reimbursement principles; provided, however, such limit shall not apply to specialized patient transport vehicles (e.g., ambulances);

5) Air transport vehicles that are not used to transport patient care staff or patients. If these vehicles are sometimes used for patient care staff or patient transport, the portion of cost that is unrelated to patient care staff or patient transport is nonallowable;

6) Ten percent (10%) of membership dues for national, state, and local associations;

7) Legal services for an administrative appeal or hearing, or court proceeding involving the provider and the Department or any other state agency when judgment or relief is not granted to the provider. Legal services associated with certificate of need issuance reviews, appeals, disputes or court proceedings are not allowable regardless of outcome. Legal services associated with a provider's initial certificate of need request shall be allowable; and

8) Advertising costs that are (a) for fund-raising purposes, (b) incurred in the sale or lease of a facility or agency or in connection with issuance of the provider's own stock, or the sale of stock held

by the provider in another corporation, (c) for the purpose of increasing patient utilization of the provider's facilities, (d) for public image improvement, or (e) related to government relations or lobbying.

Information regarding nonallowable costs for the appropriate fiscal period (as determined by the Department) will be requested from hospitals. The Nonallowable Cost Questionnaire will contain instructions for completion and the date by which the Department must receive the completed questionnaire. If the Questionnaire is not received by the due date, Medicaid payments will be withheld, as appropriate, until an acceptable Questionnaire is received.

Effective for the determination of reasonable costs used in the establishment of rates effective on and after November 1, 1991, fifty percent (50%) of membership dues for national, state and local associations are nonallowable.

Reimbursable costs will not include those reasonable costs that exceed customary charges except as outlined in HCFA Publication 15, Part 1, Chapter 26, Section 2614 (Carryover of Unreimbursed Cost).

1001.8 Reimbursement for Outlier Cases

All outlier cases under the hybrid-DRG system are determined based on cost. There are no length of stay thresholds. The determination of outliers is described further in Appendices C and M.

1001.8A Reimbursement for High Cost DRG Cases

High cost DRGs will be reimbursed a supplemental amount based on 90% of cost between the DRG base rate and the actual cost of the case.

1002. Cost Reporting Requirements

1002.1 Each participating (enrolled) hospital must submit a cost report using the appropriate Form HCFA-2552. The Department requires hospitals to list inpatient and outpatient costs and charges separately on Worksheet E-3 Part III or other revised form as appropriate.

1002.2 A hospital with a cost reporting period ending on or after June 27, 1995, must furnish its cost report within five months after its fiscal year end. If the report has not been received after this five-month period and a request for extension has not been granted, a written warning will be issued. This warning will indicate if, after an additional month (total six months), the cost report has not been received, a one hundred percent reduction will be imposed on all payments made during the period that the cost report is late.

These payments will be withheld until an acceptable Medicaid cost report is received. After the cost report is received and is determined to be acceptable, the withheld funds will be released. If the cost report is not received after a total of seven months from a hospital's fiscal year end, the hospital's agreement of participation will be subject to suspension or termination.

When a hospital undergoes a change of ownership or voluntarily or involuntarily terminates from the Medicare/Medicaid program, the hospital must notify the Department and file a terminating cost report within five (5) months of the date of termination. If a cost report is not received within this period, all Medicaid payments will be withheld until an acceptable cost report is received and accepted by the Department.

1002.3 The Department has entered into a "common audit" agreement with Blue Cross & Blue Shield of Georgia, Inc. If a hospital's Medicare fiscal intermediary is Blue Cross & Blue Shield of Georgia, Inc., the hospital's Medicaid cost report should be sent to the following address:

Provider Audit & Reimbursement Department
Blue Cross & Blue Shield of Georgia, Inc.
P.O. Box 7368
Columbus, Georgia 31908

If a hospital's Medicare fiscal intermediary is not as cited above, its Medicaid cost report should be sent to the Department at the following address:

Hospital Reimbursement Unit
Department of Medical Assistance
2 Peachtree Street, N.W.
Atlanta, Georgia 30303-3159

1002.4 As part of the cost report review process, a hospital must make available to authorized representatives of the Department all medical and fiscal records, including Medicare cost reports and workpapers prepared by Medicare fiscal intermediary auditors.

1003. Cash Settlements

1003.1 As described in Subsection 1001.3(c), a determination will be made which may show that a hospital's interim payments were less than or more than a retrospectively determined settlement amount.

1003.2 Where the determination of reimbursable cost shows that additional payments due the hospital, the Department will provide payment upon receipt, review and acceptance of an audited Medicaid cost report from the intermediary. Tentative settlement will not be made based on an as-filed Medicaid cost report or an audited report which has not been reviewed and accepted by the Department.

1003.3 Where the determination of reimbursable cost shows that an overpayment has been made to a hospital, the hospital must refund the overpayment as outlined in Section 304. A hospital also must refund the Department the amount by which total Medicaid payments are in excess of total charges for Medicaid patients.

1004. Room Rate Reimbursement

1004.1 For those hospitals subject to Subsections 1001.1 and 1001.2, the Department does not reimburse for a private room under any circumstance. The difference in the cost of private and semi-private rooms should be identified and, if appropriate, excluded in the determination of allowable cost for services provided to Medicaid patients.

1004.2 For those hospitals subject to Subsections 1001.4, the Department does not reimburse for a private room under any circumstance. This provision will, if applicable, be taken into consideration for determining the appropriate payment for services provided to Medicaid patients.

1004.3 Semi-private room rate increases will be collected periodically by the Department through a survey process. The timeframe for collecting the data and incorporating new semi-private room rate changes into the claims processing system will be specified in the survey instrument.

1005. Hospital-Based Rural Health Clinics

Hospital-based rural health clinics enrolled in the Medicaid rural health clinic program are reimbursed based on a determination of allowable and reimbursable costs. The determination of such costs is made retrospectively and is based on the hospital's cost report submitted in accordance with Section 1002 and data included in the Nonallowable Costs Questionnaire. Rural health clinic services information should be included in the hospital's cost report as an outpatient services department. Hospital-based rural health clinics are reimbursed an interim rate based on the hospital's costs-to-charges ratio, and a final determination of reimbursable costs occurs at the time outpatient settlements for all hospital services are made. One hundred percent (100%) of reimbursable rural health clinic costs are included in the hospital outpatient settlements calculated as described in Section 1003. Please reference the Policies and Procedures for Rural Health Clinic Services manual for additional information.

1006. Uncompensated Costs

Subject to the availability of funds, make payment to the hospital with the highest number of inpatient Medicaid admissions in the previous fiscal year to reimburse for uncompensated inpatient Medicaid costs and medical education costs.

1007. Inpatient Co-payments

Effective for dates of admission of July 1, 1994, and after, a co-payment of $12.50 will be imposed on hospital inpatient services.

Recipients affected by the co-payment are limited to adult recipients of Supplemental Security Income (SSI) benefits, certain other adult disabled and aged recipients and parents of children receiving Aid to Families with Dependent Children (AFDC) benefits. Children under age twenty-one (21), pregnant women, nursing facility residents, home and community based waivered recipients, dialysis recipients of hospice care participants and recipients receiving family planning services are not required to pay this co-payment. In addition, persons who have both Medicare and Medicaid coverage are not required to pay the co-payment. Emergency services received by Medicaid recipients do not require a co-payment. Services cannot be denied based on the inability to pay these co-payments.

Beginning with dates of service of January 1, 1995, co-payments will apply to the groups of recipients outlined below who were previously exempt from participation in co-payments.

1. Dialysis recipients.
2. Medicare/Medicaid dually eligible recipients.
3. Recipients in waivered services programs.

These groups are required to co-pay beginning with dates of service January 1, 1995, and after, for those services designated as co-pay services.

Maintenance dialysis services for end-stage renal disease are not designated as co-pay services and no co-payment is required for these services.